

**WISCONSIN MEDICAID**  
**PRIOR AUTHORIZATION / VISION SERVICES ATTACHMENT (PA/VA)**

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.  
**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Vision Services Attachment (PA/VA) Completion Instructions (HCF 11051A).

**SECTION I — RECIPIENT INFORMATION**

1. Name — Recipient (Last, First, Middle Initial)

2. Age — Recipient

3. Recipient Medicaid Identification Number

**SECTION II — PROVIDER INFORMATION**

4. Name — Referring / Prescribing Provider

5. Referring / Prescribing Provider's Medicaid Provider Number

6. Telephone Number — Referring / Prescribing Provider

**SECTION III — DOCUMENTATION**

7. Lenses and Frames (Lens formula information is required for all requests for frames and lenses.)

Lens formula: (L) \_\_\_\_\_ Add \_\_\_\_\_

(R) \_\_\_\_\_

☐ Replacement only

Frame name: \_\_\_\_\_

Frame manufacturer: \_\_\_\_\_

☐ Replacement only

☐ Complete appliance (lenses and frames)

8. Special Lens / Frame Request

☐ Oversize

☐ Patient supplied frame

☐ Noncontract frame (not supplied by recipient)

☐ Add over +4.00

☐ Contract lab supplied frame

Justification for noncontract frame (principal justification may not be cosmetic; principal justification must be medically / visually necessary): \_\_\_\_\_

☐ Other (provide pertinent history / findings and justification along with specifics of request): \_\_\_\_\_

If request is for a noncontract item, estimate wholesale cost: \_\_\_\_\_

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**SECTION III — DOCUMENTATION (Continued)**

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9. Tints (All requests for tints must include specific documentation of visual or medical necessity from the prescribing provider. A diagnosis of photophobia, without substantiation, is insufficient justification.)

☐ Rose 1      ☐ Rose 2      ☐ Photochromic

☐ Other tint (explain): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Justification for tint (see above): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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10. Other Vision Services Requested (Include a description of services requested, pertinent history / findings, and justification.)

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11. **SIGNATURE** — Requesting / Performing Provider

12. Date Signed

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